HOW TO OBJECT TO YOUR SUMMARY RATING

This form should be completed if you believe your Permanent Disability Summary Rating Determination is incorrect.

Complete the form, following the instructions carefully. Note there are only four (4) reasons when you may file this request. If your reasons do not fall within these four, your petition will be denied and your case will be delayed. Disagreement with the Qualified Medical Evaluator's or Primary Treating Physician's conclusions is not a reason to object to the Summary Rating.

You must submit your request within thirty (30) days of receipt of the rating.

Attach to the form copies of:

1. The Summary Rating Determination
2. The Qualified Medical Evaluator's or Primary Treating Physician's report
3. Any other information that supports your request.

Send the originals of your request to:

Administrative Director
Division of Workers' Compensation
P.O. Box 420603
San Francisco, CA 94142
Attn: Summary Rating Reconsideration

It is important you complete the Proof of Service at the bottom of the form. Instructions are on the back. A copy must be sent to the insurance company.

Keep a copy for your records.

If you need help you may call an Information and Assistance Office. The local I&A phone numbers are listed on the back of this guide.

WORKERS' COMPENSATION APPEALS BOARD
DISTRICT OFFICES

ANAHEIM, 92801
1661 N. Raymond Avenue, Ste. 200 (714) 738-4038
Information & Assistance Unit

BAKERSFIELD, 93309
1800 30th Street, Rm.100 (661) 395-2514
Information & Assistance Unit

EUREKA, 95501-0421
100 "H" Street, Rm. 201 (707) 441-5723
Information & Assistance Unit

FRESNO, 93721-2280
2550 Mariposa Street, Rm. 4078 (559) 445-5355
Information & Assistance Unit

GOLETA, 93117
6755 Hollister Avenue (805) 968-4158
Information & Assistance Unit

GROVER BEACH, 93433-2261
1562 Grand Avenue (805) 481-3296
Information & Assistance Unit

LONG BEACH, 90802-4460
300 Oceangate Street, 3rd Floor (562) 590-5240
Information & Assistance Unit

LOS ANGELES, 90013
340 West 4th Street, 9th Floor (213) 576-7389
Information & Assistance Unit

OAKLAND, 94612
1515 Clay Street, 6th Floor (510) 622-2861
Information & Assistance Unit

POMONA, 91766
435 W. Mission Blvd., Suite 300 (909) 623-8568
Information & Assistance Unit

REDDING, 96001-2796
2115 Akard, Rm. 21 (530) 225-2047
Information & Assistance Unit

RIVERSIDE, 92501
3737 Main Street, Ste. 300 (909) 782-4347
Information & Assistance Unit

SACRAMENTO, 95825
2424 Arden Way, Ste. 230 (916) 263-2741
Information & Assistance Unit

SALINAS, 93906
1880 North Main Street, 1st Floor (408) 443-3058
Information & Assistance Unit

SAN BERNARDINO, 92401-1888
464 West Third Street, Ste. 239 (909) 383-4522
Information & Assistance Unit

SAN DIEGO, 92101-3690
1350 Front Street, Ste. 3012 (619) 525-4589
Information & Assistance Unit

SAN FRANCISCO (DISTRICT OFFICE), 94102
455 Golden Gate Ave., 2nd Floor (415) 703-5020
Information & Assistance Unit

SAN JOSE, 95113
100 Paseo de San Antonio, Rm. 223 (408) 277-1292
Information & Assistance Unit

SANTA ANA, 92701-4080
28 Civic Center Plaza, Ste. 451 (714) 558-4597
Information & Assistance Unit

SANTA MONICA, 90405-5200
2701 Ocean Park Blvd., Std. 222 (310) 452-1188
Information & Assistance Unit

SANTA ROSA, 95404
50 "D" Street, Ste. 430 (707) 576-2452
Information & Assistance Unit

STOCKTON, 95202-2314
31 East Channel Street, Rm. 417 (209) 948-7980
Information & Assistance Unit

VAN NUYS, 91401-3373
6150 Van Nuys Blvd., Rm 105 (818) 901-5374
Information & Assistance Unit

VENTURA, 93003-6085
5810 Ralston Street, Rm. 115 (805) 654-4701
Information & Assistance Unit

WALNUT CREEK, 94598
175 Lennon Lane, Rm. 200 (925) 977-8343
Information & Assistance Unit

As of May 18, 2000

REQUEST FOR RECONSIDERATION OF SUMMARY RATING
TO THE ADMINISTRATIVE DIRECTOR

This form may be used by an unrepresented employee or his or her employer to request that the Administrative Director determine whether a permanent disability rating performed by the Office of Benefit Determination should be reconsidered pursuant to Labor Code Section 4061(k).

A request for reconsideration may be granted if it is shown that the Qualified Medical Evaluator (QME) has failed to address all issues, failed to completely address issues, failed to follow the procedures promulgated by the Industrial Medical Council (IMC), or if the rating was incorrectly calculated. This procedure is applicable only to injuries occurring on or after 1/1/91. Please verify that you sent a copy of this request to the other party (employee or claims administrator) by filling out the proof of service below after reading the instructions on the reverse side.

This request must be submitted within thirty (30) days of receipt of the rating.

SEND TO: Administrative Director
Division of Workers' Compensation
45 Fremont Street, 31st Floor
San Francisco, CA 94105
Attn: Summary Rating Reconsideration

INCLUDE:
(1) This completed form;
(2) A copy of the Summary Rating
(3) A copy of the Qualified Medical Evaluation (QME) Report
(4) Other information supporting the request

Employee Name:		**Disability Evaluation Unit File Number:**	
Employee Address:		**Employer/Insurer Claim Number:**	
Employer/Adjusting Agency		**Employee's Social Security Number:**	
Employer/Adjusting Agency Address:		**Date of Injury:**	

REASON(S) FOR REQUEST: *(Check reason and explain below. Attach additional sheets if necessary.)*

[ ] QME failed to address all issues
[ ] QME failed to completely address issues
[ ] IMC procedures not followed by QME
[ ] Rating was incorrectly calculated

Explanation: _____

_____

_____

_____

_____

Reconsideration of Summary Rating is being requested by: _____
(Injured worker/Employer/Claims Adjusting Agency)

PROOF OF SERVICE BY MAIL

(Instructions on Reverse)
On _____ I served a copy of this Request for Reconsideration of Summary Rating on
(date)
_____ at _____ by placing
*(name of **employee or claims administrator**)* *(address)*
a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature _____

REQUEST FOR RECONSIDERATION OF SUMMARY RATING
TO THE ADMINISTRATIVE DIRECTOR

INSTRUCTIONS FOR COMPLETING THE PROOF OF SERVICE BY MAIL

Complete the Proof of Service by Mail on the reverse side as follows:

PROOF OF SERVICE BY MAIL **(SAMPLE)**

On **#1** I served a copy of this Request for Reconsideration of Summary Rating on
(date)
#2 at **#3** by placing
*(name of **employee or claims administrator**)* *(address)*
a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature **#4**

1) List on line #1 the date on which you mailed this form

2) If you are the Injured Employee, list on line #2 the name of the Insurance Carrier of Claims Adjusting Agency handling your case. If you are the Insurance Carrier/Claims Adjusting Agency, list the name of the Injured Employee

3) List on line #3 the mailing address for the Insurance Carrier/Claims Adjusting Agency or Injured Employee you listed on line #2.

4) Sign your name on line #4